VERMONT
DEPARTMENT OF HEALTH

Part 4

Report on Vermont's Mental Health Performance Indicators in Fiscal Year 2006

SECTION III. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM.

Adults with Severe Mental Illness

Criterion 1: Comprehensive Community-Based Mental Health Service System for Individuals with Mental Illness.

Required Performance Indicators:

1. Name of National Outcome Measure: Reduced Utilization of Psychiatric Inpatient Beds (Decreased Rate of Readmission to State Psychiatric Hospitals Within 30 Days and 180 Days)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual*	FY 2006 Target % Attained*
Reduced inpatient utilization	< 30 days	< 30 days	< 30 days	< 30 days	< 30 days	< 30 days
	17/204 (8%)	24/231 (10%)	15/193 (8%)	8-10%	32/215 (15%)	100%
	< 180 days	<180 days	<180 days	<180days	<180days	<180 days
	37/204 (18%)	46/231 (20%)	37/193 (19%)	18-20%	52/215 (24%)**	100%
Numerators	# patients readmitted <30 days	# patients readmitted <30 days	# patients readmitted <30 days	# patients readmitted <30 days		
	17	24	11		32	
	# patients readmitted <180 days	# patients readmitted <180 days	# patients readmitted <180 days	# patients readmitted <180 days		
	37	46	37		52	
Denomi-nator	# patients discharged	# patients discharged	# patients discharged	# patients discharged		
	204	231	192	c. 200	215	

*One individual accounted for fifteen of the thirty-two readmissions in less than thirty days, and, thus, fifteen of the fifty-two readmissions in less than 180 days. If that outlier is taken out of the calculation, then both percentages fully meet the target range set for this measure in the summer of 2006. The arithmetic is as follows:

32 - 15 = 17; 17/215 = 8% Target was 8-10%
52 - 15 = 37; 37/215 = 17% Target was 18-20%

**Please note that the number of readmissions under 180 days is an estimate at this time because 180 days have not passed since the end of Fiscal Year 2006. Vermont will send the Center for Mental Health Services a revised actual number after December 31, 2006.

Discovering options that meet the needs of this one individual rather than any systemic approaches to reduce higher readmissions overall would seem to be the way to deal with this very out-of-the-ordinary circumstance.

In general, the preference for voluntary over involuntary treatment is strong and pervasive throughout Vermont's public mental-health system. Emergency Services screeners in the community call for admissions of adults in mental-health crises to VSH only in situations in which the person is a danger to him- or herself, or others, needs inpatient hospitalization for mental-health treatment, and other options have been determined to be unavailable or inappropriate for the needs of the individual in crisis. The preference for community-based care over institutional care is also strong and pervasive.

2. Name of National Outcome Measures: Evidence-Based Practices (Number of EBPs Provided, Number of Adults with Severe Mental Illness Receiving EBPs)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
Evidence-Based Practices (EBPs)	# EBPs Provided	# EBPs Provided	# EBPs Provided	# EBPs Provided		# EBPs Provided
	6	6	6	6	6	100%
	# Persons Receiving EBPs*	# Persons Receiving EBPs*	# Persons Receiving EBPs*	# Persons Receiving EBPs	# Persons Receiving EBPs	# Persons Receiving EBPs
	ACT: 360 FPE: 240 IMR: 200 IDDT: 500 SE: 800-900 SH: 2,400	ACT: 360 FPE: 260 IMR: 230 IDDT: 500 SE: 800-900 SH: 2,400	ACT: 360 FPE: 260 IMR: 230 IDDT: 500-600 SE: 800-900 SH: 2,400	ACT: 360 FPE: 260 IMR: 230 IDDT: 809+ SE: 826 SH: 2,400	ACT: 360 FPE: 260 IMR: 230 IDDT: 600-700 SE: 800-900 SH: 2,400	100% for all EBPs
Numerator	# EBPs	# EBPs	# EBPs	# EBPs	# EBPs	# EBPs
	6	6	6	6	6	
	# Persons	# Persons	# Persons	# Persons	# Persons	# Persons
Numerators	See above.	See above.	See above.	See above.	See above.	See above.

*Numbers for adults in ACT, FPE, and SH programs are estimates based on the best available data at the time about numbers of clients served. In the case of IDDT, the number given for Fiscal Year 2006 is the number of clients identified as having dual diagnoses of mental illness and substance abuse. For SE, the number of Community Rehabilitation and Treatment (CRT) clients employed during Fiscal Year 2006 is used as a proxy for those enrolled in Supported Employment. If recipients of Recovery Education in Vermont were added to the IMR Toolkit pilot participants, the IMR number could easily be above one thousand. The same goes

for Family Psychoeducation and the training series offered year after year by the National Alliance for Mental Illness of Vermont (NAMI—VT).

In Vermont, another practice that is very near meeting the EBP standards, Dialectical Behavioral Therapy (DBT), is available in all ten of the state's catchment areas. A few years ago, the Division of Mental Health (DMH) applied, unsuccessfully, for a grant to pilot implementation of Medication Algorithms in Vermont.

Vermont has a strong commitment to Evidence-Based Practices, Emerging Practices, and Values-Based Practices, as stated in Adult Mental Health's Policy Framework: Vermont's publicly funded adult mental health service system is committed to using all the resources available to our system to provide the best possible services to consumers and families in order to promote their recovery and full participation in our community. **Best possible** means the consistent implementation of and wide access for consumers and family members to:

- Those services and practices for which there is strong scientific evidence of their effectiveness for the CRT target population in typical community mental health settings (evidence-based practices); and
- Those services that reflect our system's values of recovery, empowerment, and community integration (values-based practices)

In addition, **best possible** means identifying, piloting, and evaluating the effectiveness of promising approaches to address issues of widespread need (promising emerging practices).

Stakeholder roles and responsibilities are as follows:

DMH

- Work to assure the availability of sufficient resources for the service system
- Pursue grant and other funding opportunities to pilot practices, subsidize training for staff, and to secure expert technical assistance for program managers and clinical supervisors
- Change or revise administrative structures (policy, procedural, and fiscal) to support implementation of evidence-based practices and values-based practices as needed; consider changes needed to support implementation of emerging promising practices
- Clearly communicate expectations for practice and program implementation to service providers
- Integrate these expectations into existing contracting, evaluation, and designation processes
- Nurture a culture in which change to improve client outcomes is an expectation
- Work to ensure that the entire system, providers, and stakeholders have the support needed to make changes effectively

Service Providers

- Actively learn about new practices
- Openly and actively pursue implementation of evidence-based practices
- Explore promising emerging practices and practices consistent with our values

- Pilot new practices with high fidelity and thoughtful evaluation of client outcomes, cost effectiveness, and compatibility with our values
- Refine and alter service and administrative structures at the agency level to support implementation of these practices
- Support a culture in which change to improve client outcomes is an expectation and ensure that staff and clinical leaders have the support they need to make changes effectively
- Ensure that evidence-based practices and practices that reflect our values are widely available to consumers and their family members

Stakeholders

- Advocate for sufficient resources in the service system
- Work collaboratively with the Vermont Department of Health (VDH), DMH, and the provider network on:
  - ✓ Piloting and implementing evidence-based practices,
  - ✓ Assisting in identifying needs and gaps yet to be addressed and promising emerging practices to meet those needs, and
  - ✓ Supporting piloting and implementation of emerging practices
- Assist VDH, DMH and the provider network to understand how our current practices could be changed for the better to support consumer recovery, empowerment, and community integration.

Implementing the Policy Framework. DMH, the provider network, and consumers and family members together commissioned the development of a Clinical Practices Advisory Panel. The purpose is to create a multi-stakeholder, consensus process by which our mental-health system makes decisions about evolving practices.

The panel is comprised of clinicians, consumers, family members, and administrators. Its role is to:

- ☙ Commission and evaluate reviews of the scientific and practice literature on emerging practices for consideration in Vermont
- ☙ Commission service pilots of promising, emerging practices and values-based practices
- ☙ For new and existing service pilots, evaluate the results for:
  - ♦ Consumer outcomes
  - ♦ Cost effectiveness
  - ♦ Compatibility with our system's values of recovery, empowerment, and community integration
  - ♦ Interaction and compatibility with existing practices
- ☙ Create recommendations for the Division of Mental Health about the scope and scale of implementation

3. Name of National Outcome Measure: Client Perception of Care (Clients Reporting Positively About Outcomes)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
Client reports of positive outcomes	Figure unavail-able*	749/ 1,100 (68%)	749/ 1,100 (68%)	749/ 1,100 (68%)	749/ 1,100 (68%)	100%
Numer-ator	# positive responses	# positive responses	# positive responses	# positive responses	# positive responses	
		749	749	749	749	
Denomi-nator	Total # responses	Total # responses	Total # responses	Total # responses	Total # responses	
		1,100	1,100	1,100	1,100	

*The CRT client survey administered in Fiscal Year 2004 was the first to include a question about client outcomes. The report on that survey was completed in February 2005. DMH surveyed CRT clients and issued reports on the results every three years in the past. Now, however, beginning with Fiscal Years 2006-2007, DMH has modified the CRT survey so that it will be administered yearly in the future. Responses to the current CRT survey are still coming in and will be available for the Fiscal Year 2008 application for block grant funding.

4. Name of Performance Indicator: Employment of CRT Clients (Number of CRT Clients Employed, for Whom Wage Data Are Reported to the Vermont Department of Labor)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
# CRT Clients Employed	835/2,980 (28%)	849/3,004 (28%)	844/2,977 (28%)	826/2,943 (28%)	850-900/ c. 3,000 (25-30%)	100%
Numer-ator	# CRT cli-ents w/ reported wages	# CRT cli-ents w/ reported wages	# CRT cli-ents w/ reported wages	# CRT cli-ents w/ reported wages	# CRT cli-ents w/ reported wages	
Denomi-nator	# CRT clients	# CRT clients	# CRT clients	# CRT clients	# CRT clients	

Securing employment is one of DMH's top two priority outcomes for CRT clients. All consumers should have encouragement and opportunities to find and keep employment of their choice. Supported Employment services with high fidelity ratings for adults with severe mental illness are available in all ten of Vermont's catchment areas.

State-Developed Performance Measures:

5. Name of Performance Measure: Monitoring and Reporting on Involuntary Treatment (Monitoring Activities and Reports on Involuntary Treatment in the Public Mental-Health System)

Goal: To continue to measure and report regularly on psychiatric hospitalizations, including involuntary hospitalizations and procedures, of adults with severe mental illnesses, with a view to reducing involuntary care in the public mental-health system. Reducing involuntary care is one of DMH's top two priorities for outcomes for CRT clients.

Target: Continuation of ongoing monitoring activities, production of regular reports, identification of trends, and action as indicated.

Indicators: Number of adults involuntarily hospitalized, number of bed days in involuntary treatment, involuntary procedures (seclusion, restraint, and psychiatric medications administered), compliance with records-keeping standards.

Sources of Information: Monitoring visits to designated hospitals, DMH's Managed Care Information System, in addition to a database from the Brattleboro Retreat and the Vermont Department of Health's Hospital Discharge Data Set, and data on orders of nonhospitalization kept by DMH's Legal Unit.

Significance: It would be ideal to have a service system without involuntary procedures. To the extent possible within available knowledge, technology, and resources, the Division of Mental Health has been working for a number of years to create or enhance alternatives that offer consumers an array of choices for voluntary care so that involuntary care will remain as low as can be achieved. Eventually, with enough voluntary options, it is possible that all mental-health care will be on a voluntary basis. Until that ideal is attained, DMH will monitor the extent of involuntary care within the public mental-health system.

The reports currently produced bring together a good bit of information from a number of providers, the Vermont State Hospital as well as five designated hospitals in the community where involuntary procedures may take place. Pulling all that information from so many different sources together into coherent reports has not been as easy as it may seem. DMH uses the data from individual designated hospitals in the designation process.

6. Name of Performance Measure: Case Management for Medicaid-Eligible Clients
(Percentage of Medicaid-Eligible Clients Receiving Case Management)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
%age of Medicaid-Eligible CRT Clients Receiving Case Mgt.	91% 2,556 2,823	94% 2,553 2,703	95% 2,734 2,872	95% 2,524 2,646	90-95%	100% 2,524 2,646
Numer-ator	Medicaid-Eligible CRT Clients Receiving Case Mgt.	Medicaid-Eligible CRT Clients Receiving Case Mgt.	Medicaid-Eligible CRT Clients Receiving Case Mgt.	Medicaid-Eligible CRT Clients Receiving Case Mgt.	Medicaid-Eligible CRT Clients Receiving Case Mgt.	Medicaid-Eligible CRT Clients Receiving Case Mgt.
Denomi-nator	# Medicaid-Eligible CRT Clients	# Medicaid-Eligible CRT Clients	# Medicaid-Eligible CRT Clients	# Medicaid-Eligible CRT Clients	# Medicaid-Eligible CRT Clients	# Medicaid-Eligible CRT Clients

Case management and other community supports from designated agencies help adults with severe mental illness maintain or improve their places in the community and reduce the need for inpatient hospitalization. Vermont's case-rate funding mechanism for CRT services permits flexible and creative uses of the available funding to meet consumers' service needs through the public mental-health system. Strong Recovery Education courses statewide, administered and conducted by Vermont Psychiatric Survivors, give consumers other skills and coping strategies to help them live independent, fulfilling lives.

Criterion 2: Mental-Health System Data and Epidemiology.

Required National Outcome Measure:

1. Name of National Outcome Measure: Increased Access to Services (Adults Served by Age, Gender and Race/Ethnicity)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2006 Target % Attained
Increased Access to Services	11,265/* 25,754** (44%)	12,721/* 26,276*** (48%)	12,979/* 26,276*** (49%)	11,000-13,000/ 25,754 (45-50%)	12,325/* 26,276*** (47%)	100%
Numerator	# clients served by programs	# clients served by programs	# clients served by programs	# clients served by programs	# clients served by programs	
Denominator	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	

*Includes 3,210 clients assigned to CRT programs in SFY 2003, 3,205 in SFY 2004, 3,145 in SFY 2005, and 3,154 in SFY 2006; 7,130 clients assigned to Adult Outpatient programs in SFY 2003, 7,120 in SFY 2004, 6,936 in SFY 2005, and 6,631 in SFY 2006; and other adults served in Emergency Services as well as those who were unassigned to any program.

**Based on Vermont adult population of 476,930 in 2002 and the federal prevalence estimate of 5.4 percent for severe mental illness.

***Based on Vermont adult population of 486,595 in 2004 and the federal prevalence estimate of 5.4 percent for severe mental illness.

State-Developed Performance Measures:

None for this criterion.

Criterion 3: Integrated System of Children's Services.

Criterion 3 does not apply to services for adults with severe mental illness.

Criterion 4: Targeted Services to Rural and Homeless Populations.

Required National Outcome Measure:

1. **Name of National Outcome Measure: Maintaining access to mental-health services for adults in all catchment areas** (Number of adults served by the public mental-health system). See access table under Criterion 1.

Goal: To continue to provide mental-health services for adults with severe mental illness and other emotional and behavioral disorders in all areas of the state.

Target: Maintenance of access to mental-health services for adults

Indicators Measured: Number of adults assigned to CRT and Adult Outpatient programs, also number of adults served but not assigned to a mental-health program

Sources of Information: Monthly service reports from designated agencies

Significance: Providing mental-health services for homeless and rural populations of adults with severe mental illness is a key requirement of the mental-health block grant law.

State-Developed Performance Measure:

2. **Name of Performance Indicator: Use of federal PATH funding to support services for adults who are severely mentally ill and homeless** (Federal PATH contracts negotiated with Vermont providers for disbursement of funding)

Goal: To continue to support services for adults who are severely mentally ill and homeless with PATH funding

Target: Use of PATH funding to maintain support services

Indicator: Contracts negotiated

Measure: Number of contracts negotiated

Sources of Information: DMH Business Office and Adult Unit Community Services Coordinator for Housing

Significance: Federal PATH funding helps provide services and supports for people who would not be willing to be engaged otherwise. The help thus obtained in building (or rebuilding) personal skills, relationships, finding work, and locating transitional or permanent housing, should bring about reductions in the distress of mental illness and homelessness. PATH funding goes into DMH contracts with seven local providers for services to persons with severe mental illness, or with dual diagnoses of severe mental illness and substance abuse, who are homeless

or at risk of becoming homeless. A Homeless Management Information System keeps track of clients served statewide and other information.

Criterion 5. Management Systems.

Financial Resources, Staffing, and Training for Mental-Health Services Providers Necessary for the Plan. Designated agencies employ 1,511 professional and paraprofessional staff members, or 418 full-time-equivalent positions (FTEs) in CRT, Adult Outpatient, and Emergency Services programs. The Adult Unit's plans for SFY 2006 training for DA staff, along with consumers and family members too, included the following:

- NAMI—VT Family-to-Family Education: training and support workshops structured to help family members understand and support loved ones with mental illness while maintaining their own well-being
- Integrated Dual Disorder Treatment: training workshops plus agency-specific consultation to community mental health staff on providing integrated mental health and substance-disorder treatment for individuals with co-occurring substance abuse and mental illness
- NAMI—VT Provider Course: forty classes focusing on helping providers work collaboratively with consumers and family members while maintaining their own well-being
- Non-abusive Psychological and Physical Intervention (NAPPI): instruction in methods of assessing, preventing, and verbally and physically managing violent or dangerous behavior by means of the least restrictive, most effective intervention possible
- NAMI—VT Provider Conference, Transforming Our Mental Health System of Care: One-day conference focusing on innovative practices for treating individuals with serious mental illness
- Supported Employment: Regular training and consultation to community mental health agencies on using Supported Employment to increase employment opportunities for consumers with mental-health issues
- Supervisory Training: Three-day workshop on developing supervisory skills for community mental health staff recently promoted to a supervisory position
- Dialectical Behavioral Therapy: Ongoing training and consultation on DBT for individuals with borderline personality disorder
- Qualified Mental Health Professional (QMHP) Training: For community mental health professionals on procedures for screening individuals for placement at the Vermont State Hospital
- Recovery Education Workshops: Workshops and classes promoting and teaching values and concepts of recovery from mental illness

<u>State-Developed Performance Measures</u>:

1. **Name of Performance Measure: Maintaining Expenditures for Community Services at Higher Levels Than for Inpatient Services** (<u>Comparison of SFY 2006 Community Funding with Funding for VSH and Inpatient Care at Designated Hospitals</u>):

Community-Based Services: $39,193,123
Vermont State Hospital: $17,271,537
Designated Hospitals: $ 3,596,599

3. **Name of Performance Measure: Expenditures of Mental-Health Block Grant Funding** (Allocations to Designated Agencies and Peer-Operated Entities and Initiatives): The funds for services for adults with severe mental illness were allocated as follows in SFY 2006:

	Projected 9/1/2005	Actual* FY 2006
1. Crisis Services to avoid unnecessary hospitalization	$ 35,000	$ 33,316
2. Community programs for adults with co-occurring disorders of mental illness and substance abuse	52,653	50,000
3. Other community-based services for adults with severe mental illness	131,564	131,564
4. Peer-operated initiatives	33,605	30,813
5. Support of peer-delivered Recovery Education activities	25,000	25,000
6. Church Street Marketplace outreach (Burlington)	25,000	25,000
7. CRT housing infrastructure funding	20,320	12,260
	$323,142	$295,693

*A reduction in Vermont's block grant allocation for Fiscal Year 2006 is reflected in the figures for Emergency Services ($1,684), community programs for adults with co-occurring disorders ($2,653), and CRT housing infrastructure funding ($1,000); $2,792 in funds for peer-operated initiatives and $7,060 in housing infrastructure funding remain to be allocated from the Fiscal Year 2006 budget.

Children and Adolescents Experiencing a Serious Emotional Disturbance and Their Families

Criterion 1: Comprehensive Community-Based Mental Health Service System for Children and Adolescents Experiencing a Serious Emotional Disturbance and Their Families.

Required National Outcome Measures:

1. Name of National Outcome Measure: Reduced Utilization of Psychiatric Inpatient Beds (Decreased Rate of Readmission to State Psychiatric Hospitals Within 30 Days and 180 Days)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
Reduced inpatient hospitali-zation	< 30 days	< 30 days	< 30 days	< 30 days	< 30 days	< 30 days
	0	0	0	0	0	100%
	< 180 days	< 180 days	< 180 days	< 180 days	< 180 days	< 180 days
	0	0	0	0	0	100%
Numer-ators	Readmis-sions in < 30 days	Readmis-sions in < 30 days	Readmis-sions in < 30 days	Readmis-sions in < 30 days	Readmis-sions in < 30 days	
	Readmis-sions in < 180 days	Readmis-sions in <180 days	Readmis-sions in <180 days	Readmis-sions in <180 days	Readmis-sions in <180 days	
Denomi-nators	# Discharges	# Discharges	# Discharges	# Discharges	# Discharges	
	Not appl.	Not appl.	Not appl.	Not appl.	Not appl.	
	# Discharges	# Discharges	# Discharges	# Discharges	# Discharges	
	Not appl.	Not appl.	Not appl.	Not appl.	Not appl.	

* The Vermont State Hospital is not intended for routine admissions of clients under eighteen years old. Consequently, admissions of adolescents to the State Hospital are rare. In Vermont Fiscal Years 2003, 2004, and 2006 no one under the age of eighteen was admitted to VSH. If anyone under eighteen does somehow enter the State Hospital, it is most likely because of a court order for a psychiatric examination in a criminal case. In SFY 2005, one person under eighteen came into VSH for a forensic psychiatric examination, was discharged and not readmitted.

2. Name of National Outcome Measure: Evidence-Based Practices (Number of EBPs Provided, Number of Children and Adolescents with a Serious Emotional Disturbance and Their Families Receiving EBPs).

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
Evidence-Based Practices (EBPs)	# EBPs Provided	# EBPs Provided	# EBPs Provided	# EBPs Provided	# EBPs Provided	# EBPs Provided
	1	1	1	1	1	100%
	# Persons Receiving EBPs	# Persons Receiving EBPs	# Persons Receiving EBPs	# Persons Receiving EBPs	# Persons Receiving EBPs	# Persons Receiving EBPs
	91	72	69	74	65-75	100%
Numer-ators	# EBPs	# EBPs	# EBPs	# EBPs	# EBPs	
	# Persons	# Persons	# Persons	# Persons	# Persons	
Denomi-nators	1	1	1	1	1	

*DMH is aware of the work that NASMHPD's Center for Mental Health Quality and Accountability has done to gather information about evidence-based practices for children and youth, but Vermont still recognizes the same two EBPs that were previously recognized for children and adolescents and their families: Therapeutic Foster Care and Multi-systemic Therapy. Therapeutic Foster Care (TFC) is an Evidenced-Based Practice that is open to Vermont children throughout the state.

Therapeutic foster care is a service provided by DMH in partnership with the Department for Children and Families. The partnership is primarily through shared funding; DCF also recruits, trains, and licenses TFC providers.

Youth in Therapeutic Foster Care have some of the most intensive needs of any clients in the System of Care for children and adolescents and their families. If they were not in TFC, they would very likely be in inpatient hospitalization, residential treatment, or an out-of-state placement.

Vermont prefers keeping families together whenever possible. An additional 101 youth received Home-Based Wraparound services in Fiscal Year 2006. Wraparound services build on the strengths of the child and family and emphasize in-home supports. Wraparound supports help children remain in their own homes with their own families. Many of these youth are also at high risk for residential treatment, out-of-state placements, or inpatient hospitalization. We believe that the numbers served in TFC are slowly decreasing because these Home-Based Wraparounds are successful in keeping the needs of these youth from rising to the higher level at which TFC would be considered appropriate for them. It is also possible that lengths of stay in TFC have increased, thus decreasing already-limited capacity because of scarce resources.

3. Name of National Outcome Measure: Client Perception of Care (Clients Reporting Positively About Outcomes)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2006 Target	FY 2006 Target % Attained
Client Reports of Positive Outcomes	62% (parents)	54% (adoles-cents)	---	66% (parents)	Rethink surveys & respond-dents	100%
Numer-ators	# Positive responses/ outcomes	# Positive responses/ outcomes	# Positive responses/ outcomes	# Positive responses/ outcomes		
	486	131	25	467		
Denomi-nators	Total # responses/ outcomes	Total # responses/ outcomes	Total # responses/ outcomes	Total # responses/ outcomes		
	778	242	71	730		

Surveys about Children's Services have been done each year for the past seven years, but respondents were different from one year to the next. The cycle of surveys included (1) children and youth assigned to Children's Services, (2) their parents, (3) providers from Child Welfare and Youth Justice (CWYJ) in the newly created Department for Children and Families, and (4) all special-education administrators and school principals.

In the past, the parents who were surveyed had Medicaid-eligible children up to the age of eighteen who received at least three mental-health services within a specified six-month period. The youth who were surveyed were Medicaid-eligible adolescents aged fourteen to eighteen who received mental-health services from DAs within a different specified six-month time period. The CWYJ providers who were surveyed served youth and their families between July and December 2003. The results of that survey are not usable here, however; the respondents were very few because of technical difficulties in implementing a Web-based format. In addition, through a methodological error, the response categories to the questions about outcomes were misstated so that they were irrelevant to the questions.

Because of temporary staffing shortages, the survey of special educators, scheduled for SFY 2005, was suspended, and the Child, Adolescent, and Family Unit rethought these surveys for the future. CAFU has decided to concentrate on clients—children and adolescents and their families—rather than try to include providers too. It should be emphasized that these surveys are not samples; they are sent to all Medicaid-eligible clients assigned to Children's Services.

For the spring of 2006, CAFU invited the parents of children who had recently received community mental-health services to complete a survey to evaluate child and adolescent mental-health programs in Vermont's ten DAs. Surveys were sent to parents of all children up to the

age of eighteen who received at least three Medicaid-reimbursed services during the period of August-November 2005.

State-Developed Performance Measures:

4. Name of National Outcome Measure: Employment Services for Youth of Transition Age (Number of JOBS programs in Vermont)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2006 Target % Attained
# JOBS programs	7	7	9	12	12	100%*
Numerator	# JOBS programs	# JOBS programs	# JOBS programs	# JOBS programs	# JOBS programs	
Denominator	1	1	1	1	1	

*Special note to Planning Council: JOBS information to be updated.

5. Name of National Outcome Measure: Case Management for Medicaid-Eligible Clients of Children's Services Programs (Percentage of Medicaid-Eligible Clients Receiving Case Management)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2006 Target % Attained
%age of Medicaid-Eligible Clients Receiving Case Mgt.	92%	84%	81%	75-85%	83%	100%
Numer-ator	# Medicaid-Eligible Clients Receiving Case Mgt.	# Medicaid-Eligible Clients Receiving Case Mgt.	# Medicaid-Eligible Clients Receiving Case Mgt.	# Medicaid-Eligible Clients Receiving Case Mgt.	# Medicaid-Eligible Clients Receiving Case Mgt.	
	5,648	5,940	6,259	6,000-6,500	6,027	
Denomi-nator	# Medicaid-Eligible Clients	# Medicaid-Eligible Clients	# Medicaid-Eligible Clients	# Medicaid-Eligible Clients	# Medicaid-Eligible Clients	
	6,132	7,040	7,747	7,500-8,500	7,271	

Criterion 2: Mental-Health System Data and Epidemiology.

Required National Outcome Measure:

Name of performance indicator: Increased Access to Services (Children and Adolescents and Their Families Served by Age, Gender and Race/Ethnicity)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2006 Target % Attained
Increased Access to Services	9,581 (62%)	10,040 (68%)	10,122 (66%)	c. 10,000+	9,812 (64%)	
Numerator	# clients served by programs	# clients served by programs	# clients served by programs	# clients served by programs	# clients served by programs	
Denominator	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	Federal prevalence estimate	

*Based on population of approximately 140,000 from birth through eighteen years of age and Surgeon General's estimate of 11 percent of youth with functional impairment because of serious emotional disturbance. See URL tables, submitted separately, for age, gender, and race/ethnicity data.

State-Developed Performance Measures:

None for this criterion.

Criterion 3: Integrated System of Children's Services.

Required National Outcome Measures:

1. **Name of National Outcome Measure: Increased Access to Services** (Children and Adolescents and Their Families Served by Age, Gender and Race/ Ethnicity)

See access table under Criterion 2, immediately above.

2. Name of National Outcome Measure: Reduced Utilization of Psychiatric Inpatient Beds (Decreased Rate of Readmission to State Psychiatric Hospitals Within 30 Days and 180 Days)

See readmission table under Criterion 1, above.

3. Name of National Outcome Measure: Evidence-Based Practices (Number of EBPs Provided, Number of Children and Adolescents with a Serious Emotional Disturbance and Their Families Receiving EBPs).

See EBP table under Criterion 1, above.

4. Name of National Outcome Measure: Client Perception of Care (Clients Reporting Positively About Outcomes)

See reports table under Criterion 1, above.

State-Developed Performance Measures:

1. Name of Performance Measure: Interagency Funding (Continuation of DMH and Department of Children and Families Roles in Families First and Other Children's Services Initiatives)

Goal: To continue to work with the Department of Children and Families (DCF) toward the integration of funding and management for treatment services for children and adolescents and their families.

Target: Continued funding from both departments for Children's Services.

Sources of Information: DMH Monthly Service Reports: DMH and DCF Business Offices.

(1)	(2)	(3)	(4)	(5)	(6)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target*	FY 2006 Target % Attained
DMH/DCF funding	$9,448,967	$9,417,925	$12,137,947	$12,000,000-$13,000,000	
Numerator	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Denominator	Not Applicable	Not Applicable	Not Applicable	Not Applicable	

*Special note to Planning Council: Still awaiting figures from the Business Office. They will be available for inclusion in the final draft to be sent to the Center for Mental Health Services.

2. Name of Performance Measure: Caseload Segregation/Integration Ratio (C-SIR) (A measure of the extent of interagency collaboration and integration in a system of care for children and adolescents and their families)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
FY	FY2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2006 Target % Attained
C-SIR	33	36	36	35-38	Figure Pending*	
Numerator						
Denominator						

*Special note to Planning Council: The Department of Education does not release its figures on students with individual education plans (IEPs) because of serious emotional disturbance until later in the year. Those data should be available for inclusion in this table sometime in November, in time to meet CMHS's deadline of December 1 for this report.

Basically C-SIR measures the degree to which local systems of care share responsibility for children and adolescents. Vermont is now measuring the overlap of caseloads among DMH, CWYJ, and Department of Education programs for youth with an emotional or behavioral disability. Because these three different agencies do not have unique client identifiers for the children and adolescents they serve, calculating the CSIR involves using a specialized statistical tool, Probabilistic Population Estimation, in conjunction with data sets from the agencies to arrive at the number of clients shared by all three (or any two of them) within acceptable degrees of certainty. For more information see John A. Pandiani, Steven M. Banks, and Lucille M. Schacht, "Caseload Segregation-Integration: A Measure of Shared Responsibility for Children and Adolescents," *Journal of Emotional and Behavioral Disorders*, Vol. 7, No. 2 (Summer 1999), 66-71. See also Banks, Pandiani, Schacht, and William M. Bagdon, "Causes and Consequences of Caseload Segregation/Integration," a paper presented at the Twelfth Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base, in Tampa, Florida, February 1999.

Criterion 4: Targeted Services to Rural and Homeless Populations.

State-Developed Performance Measures:

1. Name of Performance Indicator: Services for Rural Populations (Number of Clients Served)

Goal: To continue to provide Children's Services to rural populations throughout Vermont.

Target: Maintenance of access to Children's Services for children and adolescents experiencing a serious emotional disturbance and their families

Indicator Measured: The number of youth and families assigned to Children's Services

Sources of Information: Monthly Services Reports and other reports from designated agencies to DMH

Significance: Providing mental-health services for children and adolescents and their families is central to the mission of the Child, Adolescent and Family Unit: To assure timely delivery of effective prevention, early intervention, and behavioral/emotional health treatment and supports through a family-centered system of care for all children and families in Vermont.

2. Services for Homeless Populations in Vermont (Funding for Spectrum)

Goal: To support services for youth who are homeless and who are experiencing a serious emotional disturbance.

Target: $5,000 grant to Spectrum from federal PATH funding

Indicator Measured: Contract with Spectrum

Sources of Information: DMH Business Office; reports from Spectrum

Significance: Federal PATH funding helps provide services and supports for people who, otherwise, would probably not be willing to be engaged. The help thus obtained in building (or rebuilding) personal skills, reuniting families, going back to school, and locating transitional or permanent housing, should bring about reductions in the distress of homelessness among young people and their families.

Criterion 5. Management Systems.

Goal: To continue to use block grant funding to help support mental-health services for children and adolescents and their families.

Target: Block grant funding for providers of Children's Services

Indicator Measured: Disbursement of block grant funds to these providers

Source of Information: Business Office

Significance: The mental-health block grant supplements other sources of funding to provide needed services for children and adolescents experiencing a serious emotional disturbance and their families.

State-Developed Performance Indicators:

1. **Name of Performance Measure: Expenditures of Mental-Health Block Grant Funding** (Allocations to Designated Agencies and Other Entities): The funds will be allocated as follows in SFY 2006:

	Projected 9/1/2005	Actual* FY 2006
1. Northeastern Family Institute	$ 94,000	$ 91,043
2. Respite	$380,932	380,935
3. Consultation	$ 5,048	0
Total	$479,980	$471,978